DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

State Rapid Response Investigative Public Report

Office of Health Facility Complaints

Maltreatment Report #: HL38580003M
Compliance #: HL38580004C

Date Concluded: March 16, 2022

Name, Address, and County of Licensee Investigated:
Valley View Estates of Long Prairie
1104 4th Avenue Northeast
Long Prairie, MN 56347
Todd County

Facility Type: Assisted Living Facility with Dementia Care (ALFDC)

Evaluator's Name: Michele R. Larson, RN
Special Investigator

Finding: Substantiated, facility and individual responsibility

Nature of Visit:
The Minnesota Department of Health investigated an allegation of maltreatment, in accordance with the Minnesota Reporting of Maltreatment of Vulnerable Adults Act, Minn. Stat. 626.557, and to evaluate compliance with applicable licensing standards for the provider type.

Allegation(s):
It is alleged: The facility and the alleged perpetrator (AP) neglected the resident when the facility failed to update the resident's blood sugars in a timely manner to her primary care provider (PCP) after the PCP ordered a change to the resident's insulin. The AP told an unlicensed personnel (ULP) to administer orange juice to the resident after the resident was found unresponsive due to having high blood sugars. The resident was sent to the hospital and diagnosed with hyperglycemia, altered mental status, and acute kidney injury.

Investigative Findings and Conclusion:
Neglect was substantiated. The facility and the alleged perpetrator (AP) were responsible for the maltreatment. The resident's primary care provider (PCP) ordered the resident's blood glucose levels to be checked five times per day, however the facility only checked her blood glucose levels three times per day, causing the resident to go without a blood glucose check for 15 hours per day. Facility registered nurses (RN)'s did not regularly update the resident's PCP when the resident's blood glucose levels were out-of-range and failed to monitor the resident

after insulin changes. The resident's blood glucose levels remained elevated for approximately two weeks before the resident's PCP was notified when the resident's blood sugar was 519 mg/dL via fax. The AP, a RN, told a ULP to administer orange juice to the resident was unresponsive and did not have a low blood sugar. The facility waited two hours to call 911 after the resident was found unresponsive.

The investigation included interviews with facility staff members, including the alleged perpetrator, administrative staff, nursing staff, unlicensed staff, and family members. In addition, the investigator contacted law enforcement and reviewed the police report. The investigation included review of the resident's medical, hospital, clinic records, and ambulance report. The addition the investigation included review of the AP's employee file, other employee files, facility incident reports and policies and procedures.

The resident resided in the memory care unit in an assisted living facility. The resident's diagnoses included dementia and diabetes. The resident's service plan included assistance medication management, including management of her insulin, three times a day blood glucose checks, hourly safety checks, behavior management, assistance with walking, and personal cares. The resident required the assistance of one staff person for all walking with a wheeled walker.

The resident's RN assessment indicated the resident required frequent monitoring of her blood sugars. The RN assessment indicated the resident's blood sugars were to be monitored five times per day as ordered by the resident's PCP.

The resident's Individualized Medication Management Plan indicated the resident required assistance with medication administration and management. The resident was assessed as occasionally resisted taking medications. ULP were to attempt three times before documenting the resident refused her medications. The resident's medication management plan indicated the RN would be notified if the resident refused her medications.

The resident's record lacked evidence RN was always notified when the resident refused her medications, including insulin.

The resident's Individualized Treatment and Therapy Plan indicated the facility reduced her blood sugar monitoring from five times per day down to three times per day without an order from the resident's PCP. The resident's treatment and therapy plan indicated the RN would be notified whenever the resident's blood sugar was below 70 mg/dL, or above 300 mg/dL.

The resident's record indicated due to the decrease to three times per day blood sugar checks, there was 15-hour time frame when her blood sugars were unchecked (5:00 p.m. to 8:00 a.m.).

The resident's Individualized Treatment and Therapy Plan lacked evidence staff always notified the RN on the resident's out-of-range blood sugars.

The resident's medication administration record (MAR) indicated a facility RN transcribed the PCP's orders to continue Lantus (long acting insulin) 20 units in the morning (7:30 a.m.); change Humalog (short acting insulin) to 12 units at 8:45 a.m. and noon; discontinue Humalog 12 units at 6:30 p.m. R3's progress note indicated R3's meal insulin was withheld if R3 consumed less than 75% of her meal, although that instruction was not indicated in her PCP's orders.

The resident's MAR indicated her Humalog was withheld four times after her PCP updated her insulin order. Twice for eating less than 75% of her meal, even though her blood sugars were 239 mg/dL and 255 mg/DL, and twice unknown reasons with a morning blood sugar reading of 519 mg/dL.

The resident's blood sugar records indicated the resident's blood sugars were above 300 mg/dL for eleven days following the PCP's new insulin order. Of those 11 days, three of the resident's blood sugars were above 400 mg/dL, and one day over 500 mg/dL. In addition, the resident's blood sugar record indicated the resident received blood sugar checks two times per day during six separate days after her PCP adjusted her insulin.

The resident's record indicated the AP sent a faxed communication notifying the PCP about the resident's 519 mg/dL blood sugars. There was no record of a response from the fax or record the AP called the PCP to address the residents high blood sugar. Later that evening the resident was found unresponsive.

The resident's record indicated the facility waited 19 days to update the resident's PCP about her elevated blood sugars, even though the resident's record indicated the facility communicated with her PCP two times after the insulin was updated asking the PCP to sign the verbal orders for the insulin, yet never updated the resident's blood sugars to her PCP.

The resident's progress noted indicated one evening, ULP #1 arrived at the facility to work the 11:00 p.m. overnight shift in the memory care unit. ULP #1 noticed the resident still had her daytime clothes on and slept in a recliner. ULP #2 told ULP #1 the resident refused her dinner and only ate a cookie. ULP #2 stated the resident had not been toileted since 5:00 p.m. ULP #1 went to assist the resident to her room after performing a narcotic count and shift change report with ULP #2. ULP #1 was unable to wake the resident, and noticed the resident was drooling, with a swollen tongue and drooping lower lip. ULP #1 called the AP, who advised ULP #1 to administer thickened orange juice to the resident. The resident's blood sugar was 175 mg/dl. The resident appeared to respond slightly to the orange juice. ULP #1 and ULP #3 transferred the resident to a wheelchair and brought the resident to her room. During cares, they found the resident was incontinent of stool and urine and had a small open sore on her left buttock. ULP #1 called the AP who advised ULP #1 to call 911.

The law enforcement report indicated, at 12:51 a.m., law enforcement arrived at the facility. Upon arrival, law enforcement found the resident laying on the floor in the memory care unit,

unresponsive, appearing to be not breathing or responding to his commands. Law enforcement administered 10 liters of oxygen per minute via face mask to the resident, who started snoring and responding to his questions. Shortly afterwards, an ambulance arrived and transported the resident to the local hospital.

The resident's hospital record indicated the resident's blood sugar was 345 mg/dL upon hospital admission. The resident's hospital record indicated the facility called 911 when the resident failed to respond appropriately to shaking and painful stimuli. The hospital record indicated the resident's family did not want the resident discharged back to the facility.

During an interview, ULP #1 stated the resident was barely awake. ULP #1 stated the resident responded by answering a few yes and no questions after ULP #1 administered orange juice to the resident, stating it worked in the past.

During an interview, the resident's PCP stated blood sugars should be checked a minimum of four times per day, before meals and bedtime for patients who had unstable blood sugars. The PCP stated blood sugar checks five times per day was a reasonable amount for the resident due to her blood sugar fluctuations being insulin dependent. The resident's PCP stated it was a "risky move" to only check her blood sugars three times per day. The resident's PCP stated she questioned if the resident regularly received her insulin due to her extreme blood sugar ranges.

During an interview, family member #1 stated the resident's blood glucose level was 519 mg/dL on the day the resident went to the hospital. Family member #1 stated after the incident it took several days for the resident to return to her baseline. Family member #1 stated the resident resident's health improved after she moved to a different facility stating, "the difference was night and day."

During an interview, family member #2 stated she received a phone call at 1:00 a.m. from the facility stating a ULP found the resident unresponsive at 11:00 p.m. Family member #2 stated she asked the administrator why it took so long to call 911. Family member #2 stated the administrator was unaware of the incident and told her he would, "get to the bottom of this." Family member #2 stated she and other family members never heard from the administer again.

During an interview, the AP stated ULP # 1 notified her at 12:40 a.m., after ULP #1 and ULP #2 conducted a shift change report and narcotic count. The AP stated ULP #1 needed to call her first, stating ULP #1 was unsure of what to do. The AP stated she did not file a report with the Minnesota Adult Abuse Reporting Center (MAARC), because it did not fit the category for filing. The AP stated, "it was more of a medical thing." The AP stated she was aware the resident's blood sugars were unstable.

In conclusion, neglect was substantiated.

Substantiated: Minnesota Statutes, section 626.5572, Subdivision 19.
"Substantiated" means a preponderance of evidence shows that an act that meets the definition of maltreatment occurred.

Neglect: Minnesota Statutes, section 626.5572, subdivision 17
"Neglect" means:
(a) The failure or omission by a caregiver to supply a vulnerable adult with care or services, including but not limited to, food, clothing, shelter, health care, or supervision which is:
(1) reasonable and necessary to obtain or maintain the vulnerable adult's physical or mental health or safety, considering the physical and mental capacity or dysfunction of the vulnerable adult; and
(2) which is not the result of an accident or therapeutic conduct.
(b) The absence or likelihood of absence of care or services, including but not limited to, food, clothing, shelter, health care, or supervision necessary to maintain the physical and mental health of the vulnerable adult which a reasonable person would deem essential to obtain or maintain the vulnerable adult's health, safety, or comfort considering the physical or mental capacity or dysfunction of the vulnerable adult.

Vulnerable Adult interviewed: Unable to interview due to advanced stages of dementia.
Family/Responsible Party interviewed: Yes.
Alleged Perpetrator interviewed: Yes.

Action taken by facility:
The facility sent the resident to the hospital on the night of her unresponsive episode.

Action taken by the Minnesota Department of Health:
The facility was found to be in noncompliance. To view a copy of the Statement of Deficiencies and/or correction orders, please visit:
https://www.health.state.mn.us/facilities/regulation/directory/provcompselect.html, or call 651-201-4890 to be provided a copy via mail or email. If you are viewing this report on the MDH website, please see the attached Statement of Deficiencies.

The responsible party will be notified of their right to appeal the maltreatment finding. If the maltreatment is substantiated against an identified employee, this report will be submitted to the nurse aide registry for possible inclusion of the finding on the abuse registry and/or to the Minnesota Department of Human Services for possible disqualification in accordance with the provisions of the background study requirements under Minnesota 245C.

cc:
The Office of Ombudsman for Long Term Care
The Office of Ombudsman for Mental Health and Developmental Disabilities
Todd County Attorney
Long Prairie City Attorney

Long Prairie Police Department
Minnesota Board of Nursing

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	38580	A. BUILDING: _____ B. WING _____	C 02/09/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VALLEY VIEW OF LONG PRAIRIE IN	1104 4TH AVENUE NORTHEAST LONG PRAIRIE, MN 56347

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
0 000	Initial Comments Initial comments ******ATTENTION****** ASSISTED LIVING PROVIDER LICENSING CORRECTION ORDER In accordance with Minnesota Statutes, section 144G.08 to 144G.95, these correction orders are issued pursuant to a complaint investigation. Determination of whether a violation is corrected requires compliance with all requirements provided at the statute number indicated below. When a Minnesota Statute contains several items, failure to comply with any of the items will be considered lack of compliance. INITIAL COMMENTS: On February 9, 2022, the Minnesota Department of Health initiated an investigation of complaint #HL38580003M. At the time of the survey, there were 25 residents receiving services under the provisional assisted living license. The following correction order is issued for HL38580003M, tag identification 2360.	0 000	Assisted Living Provider 144G. Minnesota Department of Health is documenting the State Licensing Correction Orders using federal software. Tag numbers have been assigned to Minnesota State Statutes for Assisted Living Facilities. The assigned tag number appears in the far left column entitled "ID Prefix Tag." The state Statute number and the corresponding text of the state Statute out of compliance is listed in the "Summary Statement of Deficiencies" column. This column also includes the findings which are in violation of the state requirement after the statement, "This Minnesota requirement is not met as evidenced by." Following the evaluators' findings is the Time Period for Correction. PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES,"PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE. THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES. THE LETTER IN THE LEFT COLUMN IS USED FOR TRACKING PURPOSES AND REFLECTS THE SCOPE AND LEVEL ISSUED PURSUANT TO 144G.31 SUBDIVISION 1-3.	

Minnesota Department of Health
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE TITLE (X6) DATE

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02360	Continued From page 1	02360		
02360	144G.91 Subd. 8 Freedom from maltreatment Residents have the right to be free from physical, sexual, and emotional abuse; neglect; financial exploitation; and all forms of maltreatment covered under the Vulnerable Adults Act. This MN Requirement is not met as evidenced by: Based on interviews, and document review, the facility failed to ensure one of four residents reviewed (R3) was free from maltreatment. R3 was neglected. Findings include: On March 16, 2022, the Minnesota Department of Health (MDH) issued a determination that neglect and abuse occurred, and that the facility and individual person were responsible for the maltreatment, in connection with incident which occurred at the facility. The MDH concluded there was a preponderance of evidence that maltreatment occurred.	02360	No Plan of Correction (PoC) required. Please refer to the public maltreatment report (report sent separately) for details of this tag.	